VIRGINIA MEDICAID HANDBOOK



Department of Medical Assistance Services 600 East Broad Street Suite 1300 Richmond, Virginia 23219-1857

Effective March 1, 2002

MEDICAID

Medicaid is an assistance program that helps pay for medical care. To be eligible for Medicaid you must have limited income and resources and you must be in one of the groups of people covered by Medicaid. Some groups covered by Medicaid are: pregnant women, children and people with disabilities. Medicaid is not an insurance plan. It is an entitlement program funded by the State and Federal governments.

This handbook will give you basic information about Virginia Medicaid. It does not contain everything there is to know about the program. Medicaid rules change and there are many circumstances that affect eligibility. You should not use the handbook to decide if you are eligible for Medicaid. To find out if you are eligible you should apply for Medicaid at your local Department of Social Services. Local Departments of Social Services take applications and make eligibility decisions. The Department of Medical Assistance Services (DMAS) pays the physician, hospital, pharmacy or other medical service providers for care and services received by Medicaid eligible individuals.

HOW TO APPLY FOR MEDICAID

To apply for Medicaid, contact the Department of Social Services in the city or county where you live. A face-to-face interview is not required. A Medicaid application must be filed and it must be signed by the applicant unless it is completed and signed by the applicant's legal guardian, conservator, attorney-in-fact or authorized representative. Applicants for Medicaid are asked to:

- Provide Social Security numbers.
- Confirm they are Virginia residents.
- Confirm U.S. citizenship or provide documentation of alien status.
- Verify income and resources.
- Submit bills for medical services received in the past three months.

Once a completed application is received, the local Department of Social Services will determine whether you meet a Medicaid covered group and if your resources and income are within required limits. The amount of income and resources you can have and be eligible for Medicaid depends on how many people you have in your family and the covered group.

An eligibility decision will be made on your Medicaid application within 45 days, or 90 days if a disability determination is needed. The local Department of Social Services will send you a written notice that your application has either been approved or denied. If you disagree with the decision made by the local Department of Social Services, you may file an appeal.

MEDICAID COVERED GROUPS

Federal and state laws describe the groups of individuals who may be eligible for Medicaid. These groups of individuals are called Medicaid covered groups. The eligibility rules and medical services available are different for different covered groups. Individuals who meet one of the covered groups may be eligible for Medicaid coverage if their income and resources are within the required limits of the covered group. The Medicaid covered groups are:

- Pregnant women (single or married) whose family income is at or below 133% of the Federal Poverty Income Guidelines;
- Children younger than age 6 whose family income is at or below 133% of the Federal Poverty Income Guidelines;
- Low Income Families with Children (LIFC);
- Children ages 6 to 19, whose family income is at or below 100% of the Federal Poverty Income Guidelines;
- Children under age 21 who are in foster care or subsidized adoptions;
- Infants born to Medicaid-eligible women;
- Supplemental Security Income (SSI) recipients who are aged (65 or older), blind or disabled (unable to work due to severe medical conditions) and meet Medicaid resource limits:
- Individuals age 65 or older, blind or disabled, receiving long-term care services, who have income that does not exceed 300% of the SSI individual payment limit or who meet a monthly spenddown amount;
- Auxiliary Grant (AG) recipients;
- Certain people who lost SSI because their income or living situation changed;
- Persons who are terminally ill and have elected to receive hospice care;
- Individuals age 65 or older, blind or disabled who have income that does not exceed 80% of the Federal Poverty Income Guidelines;
- Women screened by the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program who have been diagnosed and need treatment for breast or cervical cancer, with income below 200% of the Federal Poverty Income Guidelines; and
- Certain refugees for a limited time period.

Medicare Related Covered Groups

Individuals who are eligible for Medicare and who meet one of the following covered groups may receive <u>limited</u> Medicaid coverage. Medicaid pays a portion of the Medicare premium on behalf of these Medicare beneficiaries.

- Qualified Medicare Beneficiaries (QMBs) must be eligible for Medicare Part A. Their income must be at or below 100% of the Federal Poverty Income Guidelines and their total resources must be not more than \$4,000 for a single person and \$6,000 for a couple. Medicaid pays the Medicare Part A and Part B premiums, coinsurance, and deductibles.
- Special Low-Income Medicare Beneficiaries (SLMBs) must be eligible for Medicare Part A. Their income must be between 100% and 120% of the Federal Poverty Income Guidelines and their total resources must not be more than \$4,000 for a single individual and \$6,000 for a couple. Medicaid pays the Medicare Part B premiums.
- Qualified Disabled and Working Individuals (QDWIs) must be eligible for Medicare Part A. Their income must be at or below 200% of the Federal Poverty Income Guidelines and their total resources must be at or below \$4,000 for a single person and \$6,000 for a couple. Medicaid pays the Medicare Part A premium.
- Qualified Individuals I (QI-1) must be eligible for Medicare Part A. Their income equals or exceeds 120% but is less than 135% of the Federal Poverty Income Guidelines. Their resources must be at or below \$4,000 for a single person and \$6,000 for a couple. Medicaid pays the Medicare Part B premiums.
- Qualified Individuals II (QI-2) must be eligible for Medicare Part A. Their income equals or exceeds 135% but is less than 175% of the Federal Poverty Income Guidelines. Their resources must be no more than \$4,000 for a single person and \$6,000 for a couple. Medicaid pays the portion of the Medicare Part B premium which is attributable to Home Health services.

RESOURCES

Medicaid applicants and recipients must report all resources that they own. Resources are money on hand, in the bank, and in a safe deposit box; stocks, bonds, and certificates of deposit; trusts; or pre-paid burial plans. Resources also include cars, boats, life insurance policies and real property.

All resources must be reported, however; not all resources are counted in determining eligibility for Medicaid. For example, the home that you own and live in is not a countable resource for Medicaid purposes.

If the value of your resources exceeds the Medicaid resource limit at the time of application you may become eligible by reducing your resources to or below the limit. Resources that are sold or given away without adequate compensation may cause you to be found ineligible for Medicaid coverage of long-term care services for a certain period of time.

INCOME

Medicaid applicants and recipients must report all income that they receive. Income includes earned income, such as wages, as well as unearned income such as Social Security, interest on savings, retirement pensions, Veteran's benefits, etc. Income is added together and compared to set limits to determine eligibility.

Individuals who meet all Medicaid requirements except that they have excess income are allowed to reduce (spenddown) their excess income by incurring medical expenses. These individuals are referred to as **Medically Needy** and their income is compared to a limit based on the area of the state in which they reside.

ENROLLMENT

Medicaid eligibility usually starts on the first day of the month of application. Medicaid can begin as early as three months immediately before the month in which you applied if there are unpaid medical bills that need to be covered and eligibility existed at the time.

If you are Medically Needy and must reduce excess income by incurring medical expenses, your eligibility for Medicaid will be effective when your medical expenses reach your spend-down amount. Your eligibility for Medicaid will continue through the end of a spend-down period. When your spend-down period is over, you must reapply if you want coverage.

Ongoing Eligibility and Changes

As long as you remain eligible, you will automatically receive Medicaid each month. You will receive written notice before action is taken to discontinue your Medicaid, unless we are unable to locate you. The local Department of Social Services will review your case at least every 12 months to determine if you are still eligible. If your circumstances change at any time, you must promptly tell your eligibility worker.

Using your Medical Assistance Card

When you are found eligible you will be mailed a Medical Assistance Eligibility Card (Medicaid card), which contains your name and identification number. You will receive a Medicaid card unless:

- you are in a nursing facility;
- you are enrolled in a Medallion II Managed Care Organization (MCO) or
- you are only eligible for payment of your Medicare premiums.

This card must be shown each time you receive a medical service. If you do not take your card, you can be treated as a private paying patient.

It is your responsibility to show your Medical Assistance card to providers at the time you go for service and to be sure the provider accepts payment from Virginia Medicaid. If you are enrolled in a Medallion II Managed Care Organization, you must show that identification card. Each time you receive a card, you must check the information on it to be sure it is correct. If it is not correct, you must contact your eligibility worker immediately.

You must use the card only to get medically necessary care. You must report incorrect information on the card to the local Department of Social Services, and must stop using the card immediately when told by the local Department of Social Services that you are no longer eligible.

Report the loss or theft of your card to the local Department of Social Services right away. Never lend your card to anyone. If it is found that a recipient shares his/her Medical Assistance card with another for purposes of medical care or to obtain drugs or Medicaid transportation, both parties will be prosecuted. Persons who obtain and/or sell drugs in a fraudulent manner by means of impersonation, willful false statement or representation or other fraudulent device, will also face prosecution under Virginia law.

MEDICAL SERVICE PROVIDERS

Regular Medicaid coverage:

Most Virginia Medicaid recipients are required to receive their medical care through managed care programs; however, some recipients receive their care through providers enrolled directly with the Department of Medical Assistance Services. If you receive your care through one of these providers, you have the freedom to choose any provider of care for medical services as long as the provider accepts Medicaid payment. If you receive services from providers who are not enrolled in Medicaid, you will have to pay the bill. Medicaid will not pay you back for the medical bills that you have paid. Try to use one doctor and one pharmacy for most of your care, and continue with that doctor unless you are referred to a specialist. To find a Medicaid enrolled provider, ask the provider or provider's representative if he or she accepts Virginia Medicaid.

Medicaid reviews the use of medical services by people enrolled. Some people need special management of their doctor and pharmacy use. If your Medicaid card has a doctor and/or a pharmacy printed on the card, you must get your care only from them unless they refer you to another provider.

Coverage through Managed Care:

Once you are eligible for Medicaid, you will receive a temporary Medicaid card to use when seeking medical care. If you are required to participate in a managed care program, in 15-45 days, you will receive a letter from DMAS requiring you to choose either a MEDALLION Primary Care Physician or a Medallion II Managed Care Organization for your health care needs. The goal of the Medicaid managed care programs is to provide access to high quality health care. Virginia has two managed care programs established to provide quality health care services to Medicaid recipients - MEDALLION and the Medallion II Managed Care Organization (MCO) program.

With your letter, you will get helpful information about the programs such as a list of MEDALLION PCPs and a Help Sheet, or a MCO Comparison Chart and a brochure. You will have approximately a month to choose a MEDALLION PCP or a MCO. If you do not make a choice, Medicaid will select a PCP or MCO for you.

MEDALLION requires that you choose a primary care provider (PCP) to manage your health care. Having a PCP to oversee your health care means you will have a medical home. Your PCP will provide primary health care services, give you referrals to other health care providers when needed, and monitor your health.

It is important that you choose a MEDALLION PCP that meets your needs. You can choose a different PCP for each person in your family who is covered by MEDALLION. Ask your family doctor if he accepts MEDALLION.

A Medallion II Managed Care Organization (MCO) is a health service organization that coordinates health care services through a network of providers that includes primary care providers (PCPs), specialists, hospitals, clinics, medical supply companies, transportation service providers, drug stores, and other medical service providers.

Once you become eligible for a Medallion II MCO and select the MCO of your choice, the MCO will mail a packet of information directly to you. This information will help you understand your coverage, responsibilities and how to use services. You will also receive a permanent MCO identification card (instead of a monthly Medicaid card).

The MCO will require you to choose a PCP in their network who will manage all of your health care needs. You are not required to enroll all members of your family in the same MCO or with the same PCP.

COVERED SERVICES

Clinic Services - These services are covered by Medicaid when they are provided in local Health Departments or other clinics that are licensed by Virginia.

Community Mental Health and Mental Retardation Services - Mental health services and mental retardation services offered through the local Community Services Boards are covered.

Dental Care Services - These services are available for children up to age 21. These services include emergency services for the relief of pain and infection, preventive treatment, routine therapeutic services such as extractions and fillings, as well as other diagnostic services. Dentures, braces, and permanent crowns, when prescribed by a dentist and pre-authorized by the Department of Medical Assistance Services are covered. Dental care for recipients age 21 or older is limited to surgery of the jaw and the reduction of any fracture of the jaw or any facial bone.

Durable Medical Supplies and Equipment - Are covered when used in the home setting as ordered by a physician as medically necessary. Some equipment and supplies must be preauthorized. Examples of covered supplies are:

- Ostomy supplies;
- Oxygen and respiratory equipment and supplies;
- Home dialysis equipment and supplies.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) - Provides services for children under age 21. These services include:

- Comprehensive health and developmental history
- Unclothed physical examination
- Nutritional screening
- Hearing and vision tests
- Appropriate immunizations
- Blood tests for lead poisoning at 12 and 24 months
- Routine laboratory tests, such as blood and urine for anemia, diabetes and parasites
- Age appropriate anticipatory guidance and patient education
- Semi-annual dental check-ups and treatment for children three years old and older; and
- Other services necessary to treat a condition found during an EPSDT examination

Eye Examinations - Routine exams are covered for recipients of any age (limited to once every 2 years).

Eyeglasses - Covered for recipients younger than 21 years of age.

Family Planning Services - Includes drugs, supplies, and devices provided under the supervision of a doctor.

Glucose Test Strips - Blood glucose self-monitoring test strips are covered for recipients with diabetes younger than 21 years of age.

Home Health Services - These are covered by Medicaid when provided by an authorized home health agency under a plan of treatment prescribed by your doctor up to a specified number of visits. The visits of a nurse and a home health aide are limited to 32 visits of each type annually. Visits after 32 for nurses must be preauthorized. Visits by a physical therapist, occupational therapist and speech and language therapist have to be pre-authorized after 24 visits.

Hospice Services – Are covered when offered in certified, Medicaid-enrolled hospices for terminally ill patients expected to live no more than six-months, as certified by a physician.

Hospital Emergency Room - Emergency room treatment is covered for real emergencies.

Inpatient Hospital Care - Medically necessary days of care up to 21 days are covered for adults. All medically necessary days are covered for children under age 21. Hospital admissions must be preauthorized, except for emergency admissions, which must be authorized within 24 hours of admission.

Inpatient Psychiatric Hospital Services for Individuals 65 Years of Age or Older - These services are available to those individuals who are receiving care in state-owned institutions for mental disease.

Long-Term Care - Pre-admission screening committees screen applicants for admission to nursing facilities and Medicaid community based care waiver programs.

Medicaid recipients in nursing facilities or Medicaid community based care waiver programs must pay a share of their income toward the cost of care and Medicaid pays the remaining cost. Included in the Medicaid-covered cost of the nursing facility care are:

- Room and board:
- Wheelchairs, geriatric chairs, walkers, and other medical equipment;
- Medical supplies, such as antiseptic lotion, bandages, gauze, incontinence pads (adult diapers) and supplies;
- Urine and blood testing agents, and syringes.

Maternal and Infant Care Coordination - Case management services by a registered nurse or social worker are covered for the high-risk pregnant woman or child.

Organ Transplants – Kidney, cornea, heart, lung and liver transplants are covered for all recipients without regard to age. Bone marrow transplants are covered for individuals over 21 years of age who have a diagnosis of lymphoma or breast cancer, leukemia or myeloma. For children under age 21, small bowel, bone marrow and any other medically necessary transplant procedures that are not experimental or investigational are covered. **All transplants except corneas require preauthorization.**

Outpatient Hospital Care - Medicaid pays for treatment in the doctor's office or for outpatient hospital clinic services that allow you to return home the same day after the test or operation is over. Some operations and tests <u>must</u> be performed in the doctor's office or outpatient clinic, as outpatient surgery. The doctor or hospital may not bill you if Medicaid denies payment because you did not need to stay in the hospital overnight, unless it was your choice to stay overnight and you agreed to pay for the hospital stay.

Physician's Services - Medicaid covers doctor's services both in the hospital and in the doctor's office. Medicaid will cover the doctor's care in the hospital for all authorized days up

to 21 days for adults. If you are younger than age 21, Medicaid will pay your doctor's bills while you are in the hospital as long as your stay is medically necessary. Most visits to the doctor's office for treatment are not limited, except that you may need a referral if you see someone other than your Primary Care Physician.

Podiatry Services (foot care) - Medicaid payment is limited to medically necessary diagnostic, medical or surgical treatment of the foot. Routine and preventive foot care is not covered. Payment for the trimming of the nails for a systemic condition such as diabetes is limited to once every 2 months.

Prenatal Expanded Services – Homemaker services for pregnant women on physician-ordered bed rest, education classes, and nutrition services are covered.

Prescription Drugs When Ordered by a Physician - Some prescription drugs are not covered by Medicaid, and others are only available from certain manufacturers. Doctors and pharmacists who are enrolled in the Medicaid program and Local Departments of Health have a list of drugs not covered by Medicaid. A doctor may prescribe or order some over-the-counter drugs equivalent to certain prescription drugs if it is cost-effective to do so.

Prosthetic Devices – Are covered when prescribed by a physician and pre-authorized by the Department of Medical Assistance Services.

Psychiatric or Psychological Services - Medicaid requires preauthorization of all visits after the first 26 sessions. No more than 26 additional sessions per year will be preauthorized.

Renal (Kidney) Dialysis Clinic Visits – Are covered for recipients with end-stage renal disease.

Rehabilitation Services -Intensive rehabilitation services must be preauthorized. Inpatient services are covered in acute rehabilitation hospitals or units. Outpatient services include physical and occupational therapy and speech-language pathology. Outpatient settings include acute and rehabilitation hospitals, rehabilitation agencies, and school divisions.

Transportation Services For Medical Treatment

- **Emergency** Medicaid pays for emergency transportation to receive medical treatment.
- **Non-Emergency** All non-emergency medical transportation is provided through a transportation broker under contract to the Department of Medical Assistance Services or through the recipient's Medallion II Managed Care Organization.

MEDICAID DOES NOT COVER THE FOLLOWING SERVICES

- Abortions, unless the pregnancy is life-threatening or health-threatening;
- Acupuncture;
- Alcohol and drug abuse therapy (except as provided through the Community Services Boards)
- Artificial insemination, in-vitro fertilization or other services to promote fertility;
- Broken appointments;
- Certain drugs not proven effective and those offered by non-participating manufacturers (enrolled doctors, drugstores, and health departments have lists of these drugs);
- Certain experimental surgical and diagnostic procedures;
- Chiropractic services;
- Cosmetic treatment or surgery;
- Day care;
- Dentures:
- Doctor services during non-covered hospital days;
- Drugs prescribed to treat hair loss or to bleach skin;
- Eyeglasses or their repair if you are age 21 or older;
- Friday or Saturday hospital admission for non-emergency reasons or admission for more than one day prior to surgery unless the admission on those days is preauthorized;
- Hospital charges for days of care not authorized for coverage;
- Inpatient hospital care in an institution for the treatment of mental disease for recipients under age 65, unless they are under age 22 and receiving inpatient psychiatric services.
- Medical care received from providers not enrolled in Virginia Medicaid or who will not accept payment from Virginia Medicaid as payment in full;
- Private duty nursing (except under Waiver programs);
- Psychological testing done for school purposes, educational diagnosis, school or institution admission and/or placement or upon court order;
- Remedial education;
- Routine dental care if you are age 21 or older;
- Routine physicals and immunizations if you are age 21 or older;
- Sterilization of recipients younger than age 21;
- Telephone consultation; and,
- Weight loss clinic programs;

If you receive a service not covered by Medicaid or you receive more services than the Medicaid limit for that service, you will have to pay those bills.

COPAYMENTS

Some Medicaid recipients must pay a small amount for services. This is called a copayment. The following people never have to pay a copayment for services covered by Medicaid:

- Children younger than age 21;
- People needing emergency care;
- People in nursing facilities and waiver recipients; and
- People in hospice programs.

Other adults must pay a charge for certain services. This is your copayment responsibility. If a copayment is due but you have no money, the provider will still give you the medical care you need, but you will be billed for the copayment. The following services are never subject to copays:

- Emergency services (including dialysis treatments);
- Pregnancy-related services;
- Family-planning services; and
- Emergency room services.

Routine copayment responsibilities include:

- \$1.00 per office visit
- \$1.00 per prescription filled
- \$3.00 per other doctor visit or encounter
- \$100 per inpatient hospitalization
- \$3.00 per outpatient hospitalization clinic visit
- \$1.00 per eye examination
- \$1.00 per clinic visit
- \$3.00 per home health visit
- \$3.00 per rehabilitation service

VIRGINIA MEDICAID WAIVERS

Virginia provides services under community-based care waivers to specifically targeted individuals. These services are not available to all Medicaid recipients in the state. The waivers and the services offered include the following:

AIDS Waiver

Provides services to qualifying individuals who have a Diagnosis of AIDS or AIDS Related Conditions (ARC) and documentation that the individual is experiencing medical and functional symptoms associated with AIDS or ARC which would require nursing facility or hospital care. The following services are offered under the AIDS Waiver:

• Case management

- Nutritional supplements
- Private duty nursing
- Personal care
- Respite care

Elderly and Disabled Waiver

Provides services to qualifying individuals 65 years of age or older <u>or</u> who are disabled <u>and</u> who meet screening criteria and are at imminent risk of nursing facility placement. The following services are offered under the Elderly and Disabled Waiver:

- Adult day health
- Respite care
- Personal care

Consumer-Directed Personal Attendant Services (CD-PAS) Waiver

Provides services to qualifying individuals 65 years of age or older or who are disabled, who meet screening criteria and are at imminent risk of nursing facility placement, <u>and</u> who have no cognitive impairments. The individual must be able to hire, train and fire, if necessary, his or her own attendant. The following service is offered under the CD-PAS Waiver:

• Personal attendant services

Mental Retardation Waiver

Provides services to qualifying individuals with a diagnosis of mental retardation and individuals under the age of 6 at developmental risk who have been determined to require the level of care provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). The following services are offered under the Mental Retardation Waiver:

- Day support
- Supported employment
- Residential supports
- Therapeutic consultation
- Personal assistance services
- Respite care
- Skilled nursing services
- Crisis Stabilization
- Environmental Modifications
- Assistive Technology

<u>Technology Assisted Waiver</u>

Provides services to qualifying individuals who need both a medical device to compensate for the loss of a vital body function and substantial and ongoing skilled nursing care. The following services are offered under the Technology Assisted Waiver:

- Private duty nursing
- Respite care
- Assistive Technology
- Personal care
- Environmental modifications

Individual and Family Developmental Disabilities (DD) Support Waiver

Provides services to qualifying individuals 6 years of age and older with a condition related to mental retardation but who do not have a diagnosis of mental retardation who have been determined to require the level of care provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). The following services are offered under the DD Waiver:

- Day support
- Adult Companion Care
- Supported employment
- In-home residential support
- Therapeutic consultation
- Personal care services
- Respite care
- Skilled nursing services
- Attendant care
- Family and caregiver training
- Crisis stabilization
- Environmental modifications
- Assistive technology
- Personal emergency response systems

MEDICAID LONG-TERM CARE SERVICES

Medicaid will cover part of the cost of care for an eligible individual receiving long-term care services in a facility (medical institution) or in a community-based care setting (CBC Waiver) when an eligible individual has mental or physical conditions requiring nursing supervision and assistance with activities of daily living. There are different eligibility rules and requirements, such as pre-admission screening, asset transfer and patient pay, that only apply to individuals who need Medicaid coverage of long-term care services. In addition, there are special income and resource rules for married institutionalized individuals who have a spouse who lives in the community.

Pre-Admission Screening

Pre-admission screening provides the authorization for Medicaid payment of facility (medical institution) and community-based care long-term care services. The screening determines whether an individual meets the level of care criteria for long-term care services.

Pre-admission screenings are completed by the following:

- For nursing facility care local teams composed of health and social service agencies or staff of acute care hospitals.
- For CBC Waivers local and hospital screening committees, Community Mental Health Services Boards, the Department of Rehabilitative Services and other entities are authorized to complete the screening.

Asset Transfer

Institutionalized applicants for Medicaid may be ineligible for a period of time if assets were transferred (sold, given away or disposed of). You will be asked about any assets you transferred in the last 36 months or 60 months if you set up a trust fund. A transfer of assets without adequate compensation can result in ineligibility for Medicaid payment of long-term care services for a period of time. The length of time depends on the value of the asset that is transferred, when it was transferred, and whether more than one transfer took place. Some asset transfers may not result in a period of ineligibility depending on the circumstances and if the Medicaid Program determines that the denial of Medicaid eligibility would cause an undue hardship.

Because the asset transfer policy is very complex, contact your local Department of Social Services if you have further questions regarding the impact of property transfer upon Medicaid eligibility. Department of Social Services staff will not advise an individual to take any specific course of action to achieve Medicaid eligibility.

Patient Pay

The amount of a long-term care patient's income, which must be paid as a share of the cost of long-term care services, is called **patient pay**. The amount is based on an individual's total monthly income with allowances made for some expenses such as, personal needs, the cost of medical insurance and the amount needed for the maintenance needs of a spouse or minor dependent child in the community.

When patient pay has been determined, the local department of social services sends a "Notice of Obligation for Long-Term Care Costs" form to the patient and the patient's representative. This form notifies the patient of the amount of patient pay that is due to the provider of Long-Term Care services.

Special Rules for Married Institutionalized Individuals

Medicaid law requires the use of special rules when determining Medicaid eligibility for a married institutionalized individual with a community spouse. These rules are referred to as spousal impoverishment protections. The income eligibility rules do not permit income of community spouses to be used in determining the nursing home or waiver recipient spouse's eligibility unless the income is actually made available. The resource eligibility rules require a resource assessment of the couple's combined resources so that an amount can be protected for the spouse remaining in the community.

When A Resource Assessment Is Completed

- A resource assessment can be requested when a spouse is admitted to a **medical** institution.
- A resource assessment must be completed when a married institutionalized individual with a community spouse applies for Medicaid.

RECIPIENT RIGHTS AND RESPONSIBILITIES

Privacy of Information

The local Department of Social Services may not give information concerning Medicaid applicants or recipients to anyone for any purpose other than one directly connected with the administration of Medicaid, unless authorized by you.

Other Medical Insurance Coverage

You may have medical insurance in addition to Virginia Medicaid. If you have other medical insurance, claims are filed first with those insurers. After other insurance companies have paid, the provider sends the claim to Medicaid for any additional payment that may be due. When Medicaid has paid claims for covered services and it is later found that another payment source was available, Medicaid will try to recover the money from the other source, whether it is commercial insurance, Medicare, Worker's Compensation, or liability insurance (if the claim is for an accident). Applicants for Medicaid must sign a statement called "Assignment of Rights to Medical Support and Third-Party Payments." If your insurance company pays you after Medicaid has paid the same bill, you must send that money to the Department of Medical Assistance Services.

If you drop private health insurance coverage or you enroll in a private health insurance plan, tell your eligibility worker at the local Department of Social Services; otherwise, payment of your bills could be delayed. If you have a Medicare supplemental policy, you can suspend your policy for up to 24 months while you have Medicaid without penalty from your insurance company. You must notify the insurance company within 90 days of the end of your Medicaid coverage to reinstate your supplemental insurance.

Third Party Liability and Estate Recovery

If you have been injured in any type of accident and have a personal injury claim, you must inform the local Department of Social Services so that Medicaid may recover payment from the person responsible for the accident. The local Department of Social Services needs the following information: the date of accident/injury, the type of accident, and the name of the attorney or insurance company, (if any).

Report the death of a Medicaid recipient to the Department of Social Services. Medicaid can recover money from the estate of any Medicaid recipient over age 55. Recovery may take place only after the death of any surviving spouse and if there are no minor or disabled children.

Out-of-State Medical Coverage

Virginia Medicaid will cover emergency medical services you receive while temporarily outside of Virginia if the provider of care agrees to participate in Virginia's Medicaid Program and to bill Medicaid. No payments are made directly to recipients for service costs incurred out of state. Rules for out-of-state care may be different if your coverage is through an HMO.

If you are enrolled in an HMO, contact them for their procedures regarding out-of-state treatment.

If you receive emergency medical services out of state from a provider not enrolled in Virginia Medicaid, tell the out-of-state providers to contact the Provider Enrollment Unit. The address is:

Department of Medical Assistance Services Provider Enrollment/Certification Unit 600 East Broad Street, Suite 1300 Richmond, Virginia 23219

Broken Appointments

It is very important for you to keep all appointments that you make. Failure to keep a medical or dental appointment is a type of abuse of Medicaid and could result in your doctor or dentist refusing to treat you any more.

Medicaid Fraud/Non-Fraud

Medicaid fraud is a deliberate withholding or hiding of information or giving false information to obtain Medicaid benefits. Medicaid fraud also occurs when a provider bills Medicaid for services that were not delivered to a Medicaid recipient or if a recipient shares his/her Medicaid number with another to acquire benefits.

Anyone convicted of Medicaid fraud in a criminal court must repay the Medicaid Program and will not be eligible for Medicaid for one year after conviction. In addition, the sentence could include a fine up to \$10,000 and/or up to 20 years in prison. Fraud and abuse should be reported to your local Department of Social Services or to (804) 786-0156.

Medicaid also has the authority to recover expenditures made for services received by ineligible recipients without fraudulent intent. This includes eligibility errors made due to a recipient's misunderstanding, agency errors or medical services received during an appeal process where the agency's action is upheld. There is no "statute of limitations" for Medicaid recoveries.

Appeals

A Medicaid applicant or recipient has the right to appeal any action, such as:

- Any decision denying or terminating Medicaid eligibility;
- Any unreasonable period of time taken to decide if you are eligible; and
- Any decision denying or terminating Medicaid-covered medical services.

Your appeal request must be sent to the Department of Medical Assistance Services Recipient Appeals Division at the address on the cover of this handbook, no later than **30 days** after the day you receive notice of the denial of your application or termination of your Medicaid

eligibility. After you file your appeal you will be notified of the date, time and location of the scheduled hearing. A decision on your appeal will be made within 90 days of the Department of Medical Assistance Services receiving your appeal request unless you or your representative requests a delay.

The Hearing Officer's decision is the final administrative decision rendered by the Department of Medical Assistance Services. However, if you disagree with the Hearing Officer's decision, you may appeal the decision to the Circuit Court in the city or county where you live.

WHO TO CONTACT WHEN YOU HAVE QUESTIONS ABOUT MEDICAID

Local Department of Social Services in your city or county

- Questions about applying for Medicaid or your eligibility for the program
- Questions about pre-admission screening for long-term care services
- To request Fact Sheets about Medicaid eligibility

Department of Medical Assistance Services

- Managed Care Helpline, call 1-800-643-2273, Mon.-Fri. 7:00 a.m. to 7:00 p.m. Translation services available.
- The Health Insurance Premium Payment Program (HIPP) or Medicare "Buy-In", call 1-800-432-5924 or (804) 225-4236.
- Medicaid Waiver Programs call (804) 786-1465.
- Problems with bills or services from providers of care, call (804) 786-6145 or write the Recipient Services Unit at the address on the back cover of this handbook.
- To report Medicaid fraud or abuse, call (804) 786-0156 or your local Department of Social Services.
- For Medicaid appeal information, call (804) 371-8488.

Virginia Department of Social Services

• For questions or complaints regarding the actions of staff employed by the local Department of Social Services, write the Virginia Department of Social Services, Bureau of Customer Service, Theater Row Building, 730 East Broad Street, Richmond, Virginia 23219.

Internet Web Site Information

- Virginia Department of Medical Assistance Services www.dmas.state.va.us
- Virginia Department of Social Services www.dss.state.va.us
- Centers for Medicare and Medicaid Services <u>www.cms.hhs.gov</u>

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES 600 EAST BROAD STREET, SUITE 1300 RICHMOND, VIRGINIA 23219
